AMENDED IN SENATE JANUARY 4, 2012

SENATE BILL No. 920

Introduced by Senator Hernandez

February 18, 2011

~~An act to amend Section 3040 of the Business and Professions Code, relating to optometry.~~ *An act to amend Sections 14166.12, 14169.5, 14169.16, 14169.17, 14169.18, 14169.41, and 14169.42 of the Welfare and Institutions Code, relating to Medi-Cal.*

LEGISLATIVE COUNSEL'S DIGEST

SB 920, as amended, Hernandez. ~~Optometry.~~ *Medi-Cal: hospitals.*

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law establishes the continuously appropriated Private Hospital Supplemental Fund, which consists of moneys from various sources used to fund the nonfederal share of supplemental payments to private hospitals. Existing law requires that the money annually transferred to this fund from the General Fund be reduced by specified amounts for the 2012–13 and 2013–14 fiscal years, and that the reductions in supplemental payments to private hospitals that result from the reductions in the amounts transferred from the General Fund be allocated equally, as specified.

This bill would make a technical, nonsubstantive change to those provisions.

Existing law, subject to federal approval, imposes a quality assurance fee, as specified, on certain general acute care hospitals for the period

of July 1, 2011, through December 31, 2013. Existing law requires that the moneys collected from the quality assurance fee be deposited into the Hospital Quality Assurance Revenue Fund. Existing law, subject to federal approval, requires that the moneys in the fund be available, upon appropriation by the Legislature, only for certain purposes, including, among other things, making supplemental payments for certain services to private hospitals, increased capitation payments to Medi-Cal managed care plans, and increased payments to mental health plans. Existing law provides that the provisions governing the various payments shall become inoperative on September 1, 2013, if the department has not received federal approval or a specified letter that indicates likely federal approval on or before September 1, 2013. Existing law also provides that the provisions governing the various payments shall remain in effect only until July 1, 2014, the date of the last payment of quality assurance fee payments, or the date of the last payment of specified payments from the department, whichever is later.

This bill would instead provide that the provisions governing the various payments shall become inoperative on December 1, 2013, if the department has not received federal approval or the specified letter indicating likely federal approval. This bill would extend the operative date of the provisions governing the various payments to January 1, 2015, and make related changes. This bill would make other technical, nonsubstantive changes to these provisions.

~~Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. Existing law prohibits a person from engaging in the practice of optometry, or taking other specified actions, without obtaining a certificate of registration from the board, and provides that the use of certain items is prima facie evidence of the practice of optometry.~~

~~This bill would make nonsubstantive, technical changes to those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14166.12 of the Welfare and Institutions Code is amended to read:

14166.12. (a) The California Medical Assistance Commission shall negotiate payment amounts, in accordance with the selective

provider contracting program established pursuant to Article 2.6 (commencing with Section 14081), from the Private Hospital Supplemental Fund established pursuant to subdivision (b) for distribution to private hospitals that satisfy the criteria of Section 14085.6, 14085.7, 14085.8, or 14085.9.

(b) The Private Hospital Supplemental Fund is hereby established in the State Treasury. For purposes of this section, "fund" means the Private Hospital Supplemental Fund.

(c) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to the department for the purposes specified in this section.

(d) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) One hundred eighteen million four hundred thousand dollars ($118,400,000), which shall be transferred annually from General Fund amounts appropriated in the annual Budget Act for the Medi-Cal program, except as follows:

(A) For the 2008–09 fiscal year, this amount shall be reduced by thirteen million six hundred thousand dollars ($13,600,000) and by an amount equal to one-half of the difference between eighteen million three hundred thousand dollars ($18,300,000) and the amount of any reduction in the additional payments for distressed hospitals calculated pursuant to subparagraph (B) of paragraph (3) of subdivision (b) of Section 14166.20.

(B) For the 2012–13 fiscal year, this amount shall be reduced by seventeen million five hundred thousand dollars ($17,500,000).

(C) For the 2013–14 fiscal year, this amount shall be reduced by eight million seven hundred fifty thousand dollars ($8,750,000).

(2) Any additional moneys appropriated to the fund.

(3) All stabilization funding transferred to the fund pursuant to paragraph (2) of subdivision (a) of Section 14166.14.

(4) Any moneys that any county, other political subdivision of the state, or other governmental entity in the state may elect to transfer to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal Medicaid laws.

(5) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal Medicaid laws.

(6) Any interest that accrues on amounts in the fund.

(e) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(f) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal financial participation to the full extent permitted by law. With respect to funds transferred or donated from private individuals or entities, the department shall accept only those funds that are certified by the transferring or donating entity that qualify for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable. The department may return any funds transferred or donated in error.

(g) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section.

(h) Any funds remaining in the fund at the end of a fiscal year shall be carried forward for use in the following fiscal year.

(i) Moneys shall be allocated from the fund by the department and shall be applied to obtain federal financial participation in accordance with customary Medi-Cal accounting procedures for purposes of payments under this section. Distributions from the fund shall be supplemental to any other Medi-Cal reimbursement received by the hospitals, including amounts that hospitals receive under the selective provider contracting program (Article 2.6 (commencing with Section 14081)), and shall not affect provider rates paid under the selective provider contracting program.

(j) Each private hospital that was a private hospital during the 2002–03 fiscal year, received payments for the 2002–03 fiscal year from any of the prior supplemental funds, and, during the project year, satisfies the criteria in Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, shall receive no less from the Private Hospital Supplemental Fund for the project year than 100 percent of the amount the hospital received from the prior supplemental funds for the 2002–03 fiscal year. Each private hospital described

in this subdivision shall be eligible for additional payments from the fund pursuant to subdivision (k).

(k) All amounts that are in the fund for a project year in excess of the amount necessary to make the payments under subdivision (j) shall be available for negotiation by the California Medical Assistance Commission, along with corresponding federal financial participation, for supplemental payments to private hospitals, which for the project year satisfy the criteria under Section 14085.6, 14085.7, 14085.8, or 14085.9 to be eligible to negotiate for distributions under any of those sections, and paid for services rendered during the project year pursuant to the selective provider contracting program established under Article 2.6 (commencing with Section 14081).

(*l*) The amount of any stabilization funding transferred to the fund, or the amount of intergovernmental transfers deposited to the fund pursuant to subdivision (o), together with the associated federal reimbursement, with respect to a particular project year, may, in the discretion of the California Medical Assistance Commission, be paid for services furnished in the same project year regardless of when the stabilization funds or intergovernmental transfer funds, and the associated federal reimbursement, become available, provided the payment is consistent with other applicable federal or state law requirements and does not result in a hospital exceeding any applicable reimbursement limitations.

(m) The department shall pay amounts due to a private hospital from the fund for a project year, with the exception of stabilization funding, in up to four installment payments, unless otherwise provided in the hospital's contract negotiated with the California Medical Assistance Commission, except that hospitals that are not described in subdivision (j) shall not receive the first installment payment. The first payment shall be made as soon as practicable after the issuance of the tentative disproportionate share hospital list for the project year, and in no event later than January 1 of the project year. The second and subsequent payments shall be made after the issuance of the final disproportionate hospital list for the project year, and shall be made only to hospitals that are on the final disproportionate share hospital list for the project year. The second payment shall be made by February 1 of the project year or as soon as practicable after the issuance of the final disproportionate share hospital list for the project year. The third

payment, if scheduled, shall be made by April 1 of the project year. The fourth payment, if scheduled, shall be made by June 30 of the project year. This subdivision does not apply to hospitals that are scheduled to receive payments from the fund because they meet the criteria under Section 14085.7 and do not meet the criteria under Section 14085.6, 14085.8, or 14085.9, which shall be paid in accordance with the applicable contract or contract amendment negotiated by the California Medical Assistance Commission.

(n) The department shall pay stabilization funding transferred to the fund in amounts negotiated by the California Medical Assistance Commission and shall pay the scheduled payments in accordance with the applicable contract or contract amendment.

(o) Payments to private hospitals that are eligible to receive payments pursuant to Section 14085.6, 14085.7, 14085.8, or 14085.9 may be made using funds transferred from governmental entities to the state, at the option of the governmental entity. Any payments funded by intergovernmental transfers shall remain with the private hospital and shall not be transferred back to any unit of government. An amount equal to 25 percent of the amount of any intergovernmental transfer made in the project year that results in a supplemental payment made for the same project year to a project year private DSH hospital designated by the governmental entity that made the intergovernmental transfer shall be deposited in the fund for distribution as determined by the California Medical Assistance Commission. An amount equal to 75 percent shall be deposited in the fund and distributed to the private hospitals designated by the governmental entity.

(p) A private hospital that receives payment pursuant to this section for a particular project year shall not submit a notice for the termination of its participation in the selective provider contracting program established pursuant to Article 2.6 (commencing with Section 14081) until the later of the following dates:

(1) On or after December 31 of the next project year.

(2) The date specified in the hospital's contract, if applicable.

(q) (1) For the 2007–08, 2008–09, and 2009–10 project years, the County of Los Angeles shall make intergovernmental transfers to the state to fund the nonfederal share of increased Medi-Cal payments to those private hospitals that serve the South Los Angeles population formerly served by Los Angeles County Martin

Luther King, Jr.-Harbor Hospital. The intergovernmental transfers required under this subdivision shall be funded by county tax revenues and shall total five million dollars ($5,000,000) per project year, except that, in the event that the director determines that any amount is due to the County of Los Angeles under the demonstration project for services rendered during the portion of a project year during which Los Angeles County Martin Luther King, Jr.-Harbor Hospital was operational, the amount of intergovernmental transfers required under this subdivision shall be reduced by a percentage determined by reducing 100 percent by the percentage reduction in Los Angeles County Martin Luther King, Jr.-Harbor Hospital's baseline, as determined under subdivision (c) of Section 14166.5 for that project year.

(2) Notwithstanding subdivision (o), an amount equal to 100 percent of the county's intergovernmental transfers under this subdivision shall be deposited in the fund and, within 30 days after receipt of the intergovernmental transfer, shall be distributed, together with related federal financial participation, to the private hospitals designated by the county in the amounts designated by the county. The director shall disregard amounts received pursuant to this subdivision in calculating the OBRA 1993 payment limitation, as defined in paragraph (24) of subdivision (a) of Section 14105.98, for purposes of determining the amount of disproportionate share hospital replacement payments due a private hospital under Section 14166.11.

(r) (1) The reductions in supplemental payments under this section that result from the reductions in the amounts transferred from the General Fund to the Private Hospital Supplemental Fund for the 2012–13 and 2013–14 fiscal years under subparagraphs (B) and (C) of paragraph (1) of subdivision (d) shall be allocated equally in the aggregate between children's hospitals eligible for supplemental payments under this section and other hospitals eligible for supplemental payments under this section. When negotiating payment amounts to a hospital under this section for the 2012–13 and 2013–14 fiscal years, the California Medical Assistance Commission, or its successor agency, shall identify both a payment amount that would have been made absent the funding reductions in subparagraphs (B) and (C) of paragraph (1) of subdivision (d) and the payment amount that will be made taking into account the funding reductions under subparagraphs (B) and

(C) of paragraph (1) of subdivision (d). For purposes of this subdivision, "children's hospital" shall have the meaning set forth in paragraph (13) of subdivision (a) of Section 14105.98.

(2) This subdivision shall not preclude the department from including some or all of the reductions under this section within the payments made under a new diagnosis-related group payment methodology for the 2012–13 fiscal year or the 2013–14 fiscal year. In the event the department includes some or all of the amounts, including reductions, within the payments made under a new diagnosis-related group payment methodology for the ~~2012–12~~ *2012–13* fiscal year or the 2013–14 fiscal year, the department, in implementing the reductions in paragraph (1) of subdivision (d), shall, to the extent feasible, utilize the allocation specified in paragraph (1).

SEC. 2. Section 14169.5 of the Welfare and Institutions Code is amended to read:

14169.5. (a) The department shall increase capitation payments to Medi-Cal managed health care plans for each subject fiscal year as set forth in this section.

(b) The increased capitation payments shall be made as part of the monthly capitated payments made by the department to managed health care plans.

(c) The aggregate amount of increased capitation payments to all Medi-Cal managed health care plans for each subject fiscal year shall be the maximum amount for which federal financial participation is available on an aggregate statewide basis for the applicable subject fiscal year as it may be adjusted pursuant to Section 14169.19.

(d) The department shall determine the amount of the increased capitation payments for each managed health care plan. The department shall consider the composition of Medi-Cal enrollees in the plan, the anticipated utilization of hospital services by the plan's Medi-Cal enrollees, and other factors that the department determines are reasonable and appropriate to ensuring access to high-quality hospital services by the plan's enrollees.

(e) The amount of increased capitation payments to each Medi-Cal managed ~~care~~ health *care* plan shall not exceed an amount that results in capitation payments that are certified by the state's actuary as meeting federal requirements, taking into account the requirement that all of the increased capitation payments under

this section shall be paid by the Medi-Cal managed health care plans to hospitals for hospital services to Medi-Cal enrollees of the plan.

(f) (1) The increased capitation payments to managed health care plans under this section shall be made to support the availability of hospital services and ensure access to hospital services for Medi-Cal beneficiaries. The increased capitation payments to managed health care plans shall commence no later than the later of December 31, 2011, or within 90 days of the date on which all necessary federal approvals have been received, and shall include, but not be limited to, the sum of the increased payments for all prior months for which payments are due.

(2) (A) To secure the necessary funding for the payment or payments made pursuant to paragraph (1), the department may accumulate funds in the Hospital Quality Assurance Revenue Fund for the purpose of funding managed *health* care capitation payments under this article regardless of the date on which capitation payments are scheduled to be paid in order to secure the necessary total funding for managed *health* care payments by December 31, 2013.

(B) To the extent feasible, the department shall accumulate funds under subparagraph (A) by retaining 10 percent of the total necessary funding from each of the 10 installments of the quality assurance fee received from hospitals under Article 5.229 (commencing with Section 14169.31), provided that the department may adjust the applicable dates and amounts as necessary to accumulate sufficient funding by December 31, 2013.

(g) Payments to managed health care plans that would be paid consistent with actuarial certification and enrollment in the absence of the payments made pursuant to this section, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payment under this section.

(h) (1) Each managed health care plan shall expend 100 percent of any increased capitation payments it receives under this section on hospital services.

(2) The department may issue change orders to amend contracts with managed health care plans as needed to adjust monthly capitation payments in order to implement this section.

(3) For entities contracting with the department pursuant to Article 2.91 (commencing with Section 14089), any incremental

increase in capitation rates pursuant to this section shall not be subject to negotiation and approval by the California Medical Assistance Commission.

(i) (1) In the event federal financial participation is not available for all of the increased capitation payments determined for a month pursuant to this section for any reason, the increased capitation payments mandated by this section for that month shall be reduced proportionately to the amount for which federal financial participation is available.

(2) The determination under this subdivision for any month in the program period shall be made after accounting for all federal financial participation necessary for full implementation of Section 14182.15 for that month.

(j) It is the intent of the Legislature that payments made available to designated public hospitals under this section shall replace, to the extent feasible, increased revenues that could be available to the hospitals under Section 14168.7 in the absence of this section and assuming other federal funds to the hospitals would not be reduced as a result of the payments. If this intent cannot be effectuated under this act, it is the intent of the Legislature to enact subsequent legislation to accomplish this purpose through other means.

~~(k) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.~~

SEC. 3. Section 14169.16 of the Welfare and Institutions Code is amended to read:

14169.16. *(a)* This article shall remain ~~in effect only until July 1, 2014, the date the last payment of quality assurance fee payments pursuant to Article 5.229 (commencing with Section 14169.31), or the date of the last payment from the department pursuant to this article, whichever is later, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.~~ *operative only until the later of the following:*

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to Article 5.229 (commencing Section 14169.31).

(3) The date of the last payment from the department pursuant to this article.

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

SEC. 4. Section 14169.17 of the Welfare and Institutions Code is amended to read:

14169.17. Notwithstanding any other provision of law, if federal approval or a letter that indicates likely federal approval in accordance with Section 14169.34 has not been received on or before ~~September~~ *December* 1, 2013, then this article shall become inoperative, and as of ~~September~~ *December* 1, 2013, is repealed, unless a later enacted statute, that is enacted before ~~September~~ *December* 1, 2013, deletes or extends that date.

SEC. 5. Section 14169.18 of the Welfare and Institutions Code is amended to read:

14169.18. ~~(a)~~ If the director determines that this article has become inoperative pursuant to Section 14169.13, *14169.16,* 14169.17, or 14169.40, the director shall execute a declaration stating that this determination has been made *and stating the basis for this determination.* The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the ~~Legislature.~~

~~(b) In~~ *Legislature. In* addition ~~to the requirements specified in subdivision (a)~~, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

SEC. 6. Section 14169.41 of the Welfare and Institutions Code is amended to read:

14169.41. *(a)* This article shall remain ~~in effect only until January 1, 2015, the date of the last payment of quality assurance fee payments pursuant to this article, or the date of the last payment from the department pursuant to Article 5.228 (commencing with Section 14169.1), whichever is later, and as of that date is repealed, unless a later enacted statute, that is enacted before that date, deletes or extends that date.~~ *operative only until the later of the following:*

(1) January 1, 2015.

(2) The date of the last payment of the quality assurance fee payments pursuant to this article.

(3) The date of the last payment from the department pursuant to Article 5.228 (commencing with Section 14169.1).

(b) If this article becomes inoperative under paragraph (1) of subdivision (a), this article shall be repealed on January 1, 2015, unless a later enacted statute enacted before that date, deletes or extends that date.

(c) If this article becomes inoperative under paragraph (2) or (3) of subdivision (a), this article shall be repealed on January 1 of the year following the date this article becomes inoperative, unless a later enacted statute enacted before that date, deletes or extends that date.

SEC. 7. Section 14169.42 of the Welfare and Institutions Code is amended to read:

14169.42. ~~(a)~~ If the director determines that this article has become inoperative pursuant to Section 14169.37, 14169.38, ~~or~~ 14169.40, *or 14169.41,* the director shall execute a declaration stating that this determination has been made *and stating the basis for this determination*. The director shall retain the declaration and provide a copy, within five working days of the execution of the declaration, to the fiscal and appropriate policy committees of the ~~Legislature.~~

~~(b) In~~ *Legislature. In* addition ~~to the requirements specified in subdivision (a)~~, the director shall post the declaration on the department's Internet Web site and the director shall send the declaration to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

~~SECTION 1. Section 3040 of the Business and Professions Code is amended to read:~~

~~3040. (a) It is unlawful for a person to engage in the practice of optometry or to display a sign or in any other way to advertise or hold himself or herself out as an optometrist without having first obtained a certificate of registration from the board under the provisions of this chapter or under the provisions of any former act relating to the practice of optometry. The practice of optometry includes the performing or controlling of any acts set forth in Section 3041.~~

~~(b) In any prosecution for a violation of subdivision (a), the use of test cards, test lenses, or of trial frames is prima facie evidence of the practice of optometry.~~

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